

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318 2103615

SL-19211003

8478

-62-032555

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED SEP 10 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN **St Louis**Length of stay in 1b
13 Daysc. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION **Vets Adm Hospital**Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE **Missouri** b. COUNTYc. CITY
OR
TOWN **St Louis**Inside Limits
Yes ☒ No ☐d. STREET
ADDRESS (If outside, give location)
5708 LindenwoodReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

John G Howlett4. DATE
OF
DEATH

Month Day Year

8/31/62

5. SEX

Male

6. COLOR OR RACE

White7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

12/7/98

9. AGE (last birthday)

63IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cabinet Maker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

East St Louis, Ill.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

George Howlett

13b. MOTHER'S MAIDEN NAME

Hettie Goldman

14. NAME OF HUSBAND OR WIFE

Grace E. Howlett15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)**Yes****WW I**

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Grace E. Howlett (wife) See 2 above18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Bronchopneumonia

DUE TO (b)

Cerebral Vascular Accident with Debilitation

DUE TO (c)

331XINTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY

Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. **VA** attended the deceased from **8/19/62** to **8/31/62** and last saw him alive on **8/31/62**Death occurred at **3:30 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

Removal**9-4-62****Lakewood Park****St. Louis County, Mo**

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Hoffmeister Colonial, 6464 Chippewa**AUG 31 1962****Reed Smith, M.D.**

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Bill C. Brannon

Licensed Embalmer No. 4764

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.